DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER: 0 1 — 0 0 3

2. STATE: CO

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42CFR 491 Subpart A
42 CFR 405 Subpart X

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 0
b. FFY 2002 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19B,
page 3A, 3B
and page I-A

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19B,
page 3A
and page I-A

10. SUBJECT OF AMENDMENT:
FQHC and RHC Reimbursement

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
As per Governor's letter dated 12-14-94

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Richard C. Allen

14. TITLE:
Director, Office of Medical Assistance

15. DATE SUBMITTED:
March 30, 2001

16. RETURN TO:
Health Care Policy and Financing
1575 Sherman Street, 4th Floor
Denver, CO 80203-1714
Attn: Deborah Collette

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:
March 23, 2001

18. DATE APPROVED:
6/11/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
1/1/01

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
David Selleck

22. TITLE:
Acting Associate Regional Administrator

23. REMARKS:

POSTMARK: Handcarried 3/23/01



*Instructions on Back*

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – FEDERALLY QUALIFIED HEALTH CENTER (FQHC) SERVICES

Effective September 1, 1990, the Colorado Medical Assistance Program shall reimburse Federally Qualified Health Centers (FQHCs) 100 percent of costs which are reasonable and related to the cost of providing FQHC and other ambulatory care services.

All FQHCs including hospital-affiliated and non-hospital-affiliated health centers are required to file annual cost reports. Audited cost data from these reports will be compiled for all participating FQHCs and will be used to set yearly FQHC reimbursement rates. The State will determine and assure that the payments are based upon, and cover, the reasonable costs of providing services to Medicaid beneficiaries.

Effective January 1, 2001, the payment methodologies for FQHCs will conform to section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106-554. The State will continue paying a per visit rate to each FQHC based on 100% of reasonable cost as the allowed alternative payment methodology, but reserves the right to conform to the BIPA 2000 requirements Prospective Payment System (PPS). The alternative payment methodology will be agreed to by the State and the FQHC, and will result in payment to the FQHC of an amount that is at least equal to the Prospective Payment System payment rate. The State will annually recalculate the clinic or center reasonable cost per visit for fiscal years 1999 and 2000 plus the Medicare Economic Index for primary care services to insure that the alternative rate is at least equal to or greater than the PPS rate.

In the case of any FQHC that contracts with a managed care organization, supplemental payments will be made pursuant to a payment schedule agreed to by the State and the Federally-qualified health center, but in no case less frequently than every 4 months, for the difference between the payment amounts paid by the managed care organization and the amount to which the center is entitled under the higher of the alternative payment methodology and the prospective payment system.

New free-standing FQHCs shall file a preliminary FQHC Cost Report with the Department. Data from the preliminary report shall be used to set a reimbursement rate for the first year. A base rate shall be calculated using the audited cost report showing actual data from the first fiscal year of operations as a FQHC. This shall be the FQHC's base rate until the next rebasing period.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

8. Rural Health Clinic Services – Reimbursement shall be made according to the following:

A. For provider clinics, payment will be made on a cost per visit basis according to the principles specified in the appropriate Medicare regulations. A "provider clinic" is a clinic which is an integral part of an institution which participates in Medicare. Such a clinic must also be operated under common licensure, governance and professional supervision with other departments of the institution.

B. For any clinic that is not a "provider clinic," and does not furnish any ambulatory services other than rural health clinic services, payment will be at the reasonable cost per visit rate established for the clinic by the Medicare carrier.

C. Ambulatory services covered by the program which are not rural health services will be reimbursed according to the approved level for such services. Rural health clinic services, however, will be paid at the Medicare reimbursement rate as specified above.

D. The rural health clinic service rate per visit will be subject to reconciliation after the close of the reporting period.

E. The rural health clinic service rate per visit is also subject to HHS screening guidelines or tests of reasonableness.

F. Effective January 1, 2001, the payment methodologies for rural health clinics will conform to section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106-554. The State will continue paying a per visit rate to each rural Health clinic based on 100% of reasonable cost as the allowed alternative payment methodology, but reserves the right to conform to the BIPA 2000 requirements Prospective Payment System (PPS). The alternative payment methodology will be agreed to by the State and the rural health clinic, and will result in payment to the rural health clinic of an amount that is at least equal to the Prospective Payment System payment rate. The State will annually recalculate the clinic or center reasonable cost per visit for fiscal years 1999 and 2000 plus the Medicare Economic Index for primary care

services to insure that the alternative rate is at least equal to or greater than the PPS rate. New rural health clinics will be paid at the appropriate Medicare rate.

G. In the case of any rural health clinic that contracts with a managed care organization, supplemental payments will be made pursuant to a payment schedule agreed to by the State and the rural health clinic, but in no case less frequently than every 4 months, for the difference between the payment amounts paid by the managed care organization and the amount to which the center is entitled under the higher of the alternative payment methodology and the prospective payment system.